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Dr. ROBERT C. MYLES, New York.
Dr. S. O. VANDERPOEL, New York.
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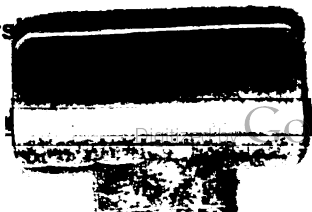
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H. HOLBROOK CURTIS, M. D.

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EDITORIAL.

It is considered among medical men, that to obtain a patent upon an instrument, is to do something not in accordance with the properly accepted views of the profession. The question is a debatable one, however, in view of the many modifications which eager practitioners at once put upon every new instrument offered, and advance under their own names. It is presumable that every instrument when presented is capable of improvement, but those improvements should be made by the inventor at the suggestion of whoever finds a practical alteration to be of value. In no other direction is this fever for modification so rife as in throat instru-

ments. When a man has devoted months of study to the moulding and improving of so important an instrument as the intubation tube or canula, it must certainly be disheartening to see crowded into the market all sorts of devices which instrument makers push as improvements upon the original, but which in reality are entirely inadequate to perform the function expected of them. It was evident to every American at the recent Medical Congress in Berlin, how little the practice and process of intubation was understood in Europe. The reason was easily explicable to the casual observer, when the imperfect instruments were shown, instruments which had become so modified by the foreign makers that the ends sought to be accomplished were rendered impossible. The intubating tubes of the French makers showed heads so thin that the epiglottis was sure to become lacerated, while the common fault of almost all the tubes of the English makers was, in that they were so sharp at the lower anterior extremity that an excoriation of the trachea was inevitable during the act of swallowing.

Intubation of the larynx holds out such bright anticipations, that it were indeed a mistake to hinder the evolution of the tube, by individual makers affecting improvements which prove inadequate to the occasion, and simply harm the patient. This line of reasoning holds good in respect to almost every instrument. Brown's saw becomes Jones' saw because the handle is bent; it is only the handle however, but Brown retires into obscurity and the saw is known generally as Jones'. Robinson bends the handle half way back again, and because it is a slight improvement the

saw becomes known as Robinson's. Meanwhile, poor Brown, believing in reciprocity, bends down the shank of the snare which Jones has invented and becomes noted in nose literature; and so the thing goes on until each claims to have invented the same instruments at identically the same time. It is rather refreshing to notice now-a-days when one professional man acknowledges that the other has perhaps anticipated his invention. The chief aim in life to some people seems to be to get their names implanted upon every instrument that is brought out. If these views are correct, there certainly would be some protection, and in many cases to the patient, by having an important instrument patented, thus avoiding those unimportant changes which are mainly undertaken with the object of notoriety in view.

Original Articles.

The Spray in Throat Practice.

BY HENRY SCHWEIG, M.D., NEW YORK.

DURING the past decade in which many of the most important advances in surgery and surgical appliances have been made, it has been a significant fact that while much has been added to the armamentarium of the laryngologist and rhinologist many really useless methods have been retained and the use of crude and unsatisfactory instruments persisted in where topical measures were indicated in diseases of the upper respiratory tract. There has been a tendency to retain time-honored methods to the exclusion of more modern, and in most instances, better ones, and thus the danger of perpetuating procedures having nothing special to recommend them, but their antiquity, is threatened.

Of nothing is this more true than the spray. It is true there are special conditions of the acute inflammatory type where contact of even the softest sub-

stances will cause suffering and distress and where the use of the spray is admissible, owing to the want of tolerance on the part of the patient, but further than this it has no excuse for existence. May I be permitted to summarize in a few words some of the objections that obtain in the use of this apparatus.

In making topical applications to any portion of the upper respiratory passages, we do so for the purpose of influencing the parts to which a given medicament is applied; and must assume that the drug is so exhibited as to come in direct contact with the affected tissues. In the use of the spray, unless high pressure is employed, practically no impression is made upon the mucus surface against which it is directed; in fact, the viscid, stringy mucus covering the parts is rarely disturbed thereby, at any rate not to the extent of laying bare a clean surface to be acted upon by the contents of the spray producer. Further, if the spray is sufficiently powerful to effect the mechanical removal of the morbid material covering the parts in question, it may do harm, and frequently does harm by reason of its strong impact, causing erosions of the surface which not infrequently end in ulceration, leaving troublesome and annoying cicatrices.

But assuming that it really may reach the parts and exert its influence, by what right do we apply it simultaneously to healthy tissues as well? No one can justify this, nor can it be avoided as in the use of the spray we cannot act locally, the very nature of the instrument determining the general distribution of the medicament.

I do not suppose that any one will undertake to reply as to the ultimate destiny of the spray when it meets with an obstruction. That according to physical laws it is in part nebulized and deflected by striking any obstruction that may project into the field is clear. In how far the contact of drugs which affect

diseased portions to which they may be applied will affect those healthy surfaces that are also included in the spray that is used, I am not prepared to say; but it will appeal to the careful thinker that the process is thoroughly irrational; for if a given drug of a certain potency exerts an influence upon a diseased surface, it is reasonable to assume that it will also affect a healthy surface in a certain measure. Drugs do not necessarily, when topically applied, have a selective action on pathological structures only.

The persistency with which the spray is employed in catarrhal conditions of the upper air passages, the abiding faith of patients who present themselves to the laryngologists at short intervals for months—sometimes years—all go to prove that there is something radically wrong. Of late years the more enlightened practitioner has looked a trifle further than the mere symptomatic manifestations in the shape of pus or muco-pus that may cover a diseased Schneiderian membrane, has discarded the sprays almost entirely, and taken up the snare, saw, trephine and galvano-cautery for the correction of conditions that stand in causative relation to the catarrhal discharges, with results both gratifying and lasting, and certainly much more prompt than when reliance was placed entirely upon nebulized liquids. It is a significant fact that a given drug employed in certain cases will, if properly applied, yield results both rapid and favorable, while the same drug though applied previously in the form of spray, made no appreciable impression. In a word, the persistent use of the spray threatens to interfere in a measure with progress on account of its convenience and the possible momentary relief it may afford, and for this reason I am fully convinced that investigation and close examination of cases are frequently neglected.

As a cleansing agent for the exhibition of antiseptic solutions, the spray is likewise delusive. We cannot by its use

really remove any material that may be present, but at the best simply loosen or displace it, leaving the matter of ultimate removal to the patient, a procedure that may be effective from a practical standpoint, but certainly not from an æsthetic one. Absorbent cotton, medicated if preferred, and held by a suitable instrument, sufficiently rigid to prevent its introduction into narrow passages, will accomplish the removal of morbid material more quickly and thoroughly and without any efforts at assistance on the part of the patient, and will not, as in the case of the spray, simply scatter pathological products upon the surrounding tissues. Danger attends the use of the spray tube and thorough asepsis of the spray armamentarium is impossible. I have seen grave disease of the middle ear produced by the employment of high pressure sprays as well as the syringe. Great danger attends the use of the spray, as a thoroughly aseptic condition of the whole armamentarium is practically impossible.

I have observed both in clinical and private practice the manner in which the spray tube is employed, and had I been an advocate of its use at any time I would certainly have discarded it promptly, owing to the impossibility of combining cleanliness with its employment. A recklessness almost criminal seems to prevail on the part of practitioners who will see patient after patient without going through the necessary formality of removing saliva, mucus, etc., from the tubes. In not a single instance, from my observation, was a tube after introduction into the anterior nares or mouth carefully cleansed or disinfected. It was either returned to the rack directly, or possibly the farce of superficially wiping it was gone through with. A close examination in not a few instances showed small incrustations upon the tubes especially where they are cemented together, and an inspection of the entire spray armamentarium showed a gross violation of the cardinal laws of antiseptis.

Biniodide of Mercury with Ipecac in Syphilis.

BY H. HOLBROOK CURTIS, M.D.

THE addition of an eighth of a grain of pulverized ipecac to a sixteenth of a grain tablet triturate of biniodide of mercury, will effectually prevent the unpleasant action of the drug upon the mucous membrane. Looseness of the bowels and gastralgia are prevented, and this dose may be given in from three to twelve pills per day. It has been the custom of the writer to continue this treatment for two years without iodide of potash. This method is particularly applicable in the case of singers, upon whom the exhibition of iodide of potash causes hoarseness; and in the case of travelers, who may carry in small bulk enough tablets to last the entire course of treatment. Over thirty cases have been treated in this manner without any potash whatever during the last ten years, with not a single tertiary symptom.

It is a fact not generally appreciated that the iodide of potash eruption and unpleasant symptoms may be prevented by the simple means of a hot bath morning and evening. This accounts for the fact that the iodide treatment is more successful at the Hot Springs than elsewhere. Many patients who suffer from disagreeable symptoms of iodism from a five or ten grain dose three times a day, may be pushed to forty and sixty grain doses without inconvenience, provided a very hot bath is taken for fifteen minutes morning and evening an hour after the doses. Hydro-therapy is invaluable in the exhibition of any drug where the entire system must be reached, for during the time the blood is holding the medication in solution the primary engorgement and secondary contraction of the peripheral capillaries in a hot bath or pack acts as a triple expansion cylinder to impart an added force and potency to the

action of the drug, and at the same time to apparently modify its disagreeable effects.

A Case of Large Turbinated Growth Complicated with Cleft Palate.

WENDELL C. PHILLIPS, M.D., NEW YORK.

M. K., aged 13, came to the Manhattan Eye and Ear Hospital, January 29th, 1890. He had a cleft of both hard and soft palate, with the usual symptoms of defective phonation, catarrh, regurgitation of food, etc. In addition to this affection of the palate he had a very large posterior hypertrophy of the left inferior turbinated bone. This was plainly visible through the cleft, and by the aid of a small mirror could be easily studied in all its aspects. It projected backward from the turbinated bone, was oval in shape, its largest diameter being at its anterior aspect. Its surface was pale in color and nodular. It filled the fossa of Rosenmüller and overlapped the orifice of the Eustachian tube.

The ear of the affected side was the seat of a chronic otitis media, caused no doubt by the above mentioned conditions. The vomer was imperfectly developed, and the main part of the inferior surface was attached to the right border of the cleft, and a portion of the posterior inferior surface was absent altogether. The septum was deviated to the left.

I propose to remove the turbinated growth through the cleft and afterwards to do a staphylorrhaphy.

A Rare Case of Bronchial Calculi.—A woman of thirty years, during her second pregnancy expectorated a bloody sputum containing a small, whitish-yellow calculus. One year afterward she expelled a second stone, and becoming pregnant again, still another; two years afterwards two other stones were evacuated. An analysis of the symptoms causes the author to attribute the foreign bodies to a mucous origin (bronchial).—*Times & Register*.

Proceedings of Societies.

American Laryngological Association.

MEETING HELD IN BALTIMORE, MAY 29,
30 AND 31, 1890.

A Suggestion Concerning the Intimate Relationship between Bulbo-nuclear Disease and Certain Obscure Neurotic Conditions of the Upper Air-passages. By Dr. John N. Mackenzie, of Baltimore. The reader stated that the reciprocal relationship between lesions of the central nervous apparatus and certain morbid phenomena exhibited in the upper respiratory tract, is a subject of surpassing interest, and one, strange to say, upon which comparatively little original work has been done. There has been too great a tendency for specialists to confine research within exact anatomical limits, and within too contracted a sphere of observation. The text-books give very little attention to this interesting class of cases, and what is given is in terms vague and indistinct. Functional aphonia, and the affections which Sir Morell Mackenzie has named "spasm of the tensors of the vocal cords," are illustrations. What do we know concerning the pathology of either of these? They are expressions of some central trouble, but we know absolutely nothing of their primary cause or essential nature. The close nervous relations existing between the nasal chambers and the medulla and sympathetic nervous system, the lecturer had had occasion to refer to in previous communications, and would not further discuss. The present paper refers especially to bulbar lesions with symptoms of disorder in the upper air-passages. The case reported was that of a widow aged about forty, whose husband had been a drunkard, who had died about a year before she came under observation. Her own habits had been always good; she had not been infected by syphilis. She had been subjected to much mental strain

and worry, and, although she had not been nervous previously, her friends had noticed that she became so after her husband's death. A short time subsequent to that event, while at house-work, her face became suddenly drawn to the left, especially the corner of the mouth. No difficulty in articulation occurred, and in three days the attack passed off. After an interval of perfect health, she was attacked by partial loss of power in her right hand, with loss of sensation; there was tingling in the lower extremities without loss of power. This tingling sensation was also felt in the throat. She attributed the attack to over-work; she having carried wet clothes on her arm the day previous. These symptoms gradually disappeared; but a difficulty in articulation ensued, without aphasia; mouth again drawn to one side (the left). Several weeks after these symptoms had subsided, while sweeping her room, she was seized with foaming at the mouth, and puffing out of the cheeks, with tingling in the right hand. She could only mumble a few unintelligible words. No fall or convulsion. She walked up stairs to bed. Legs were swollen. About six weeks later she had slight dysphagia, pain in the back of her neck and shooting pains in her hands. These symptoms also passed away. When she came under observation there was slowness in movement of the tongue; it could not be lifted to the roof of the mouth, nor above the upper lip. The mouth was drawn at the angles; she could not whistle, nor blow out a candle at a greater distance than a foot from the mouth. Some difficulty in mastication, in facial muscles, and in movements of the muscles of expression. Complete paralysis of soft palate and uvula; reflex excitability there and in the pharynx notably diminished. Voice had nasal twang. Rhinoscopic examination negative. Saliva thick, tenacious; difficulty in expectorating; requiring its removal with the finger or handkerchief. General muscular weakness, without paralysis.

Temperature normal, respiration, 30. Slight dyspnoea, much increased by exercise. Patient has hysterical spells of noisy crying and laughing.

The patient was only seen once; because she received an unfavorable prognosis, she never returned. Sufficient data, however, were obtained to demonstrate the bulbar-nuclear nature of the case. If in this class of disorders, neurologists and laryngologists could work together, more light would doubtless be thrown upon their pathology.

Dr. Bosworth considered the case as one of neuritis, especially of trifacial, and could not see why it should be called one of bulbar disease. Moreover, if the latter, it would be necessary to determine what form; whether a clot or a thrombus, or softening or a tumor. The diagnosis of bulbar disease is not enough.

Dr. Delavan said that ever since Gottstein directed our attention to the throat symptoms of bulbar disease, there has been a tendency to refer all cases of nervous origin to a central lesion. Many of these cases are of bulbar disease, but it is possible for the central lesion to be other than bulbar. Indeed, cases have been reported where it was shown to have been cortical. While we may not at present be able to clinically differentiate these cases, yet it is very possible that we shall be able to do so in the future, by the combined work of neurologists and laryngologists.

Dr. Bosworth was not aware of any well-established case in which laryngeal paralysis was caused by a cortical lesion; no case in which it was shown, by post-mortem, conclusively, that the cause was not in the bulb, but in the brain. Long before Gottstein, Hughlings Jackson had shown that in some cases of laryngeal paralysis the lesion is in the medulla.

Dr. Delavan said it had been demonstrated that cats, dogs and monkeys have a cortical centre for the movement of the larynx, and it is probable that it exists also in man, though less developed perhaps. In some cases the bulbar lesion is demon-

strated after death; in others no such lesion can be found; and the cause must lie in the hemispheres, more or less deeply in the cortex, as suggested by Ferrier.

Dr. Bosworth: The psychical centre must lie in the cortex. This can be conceded, but the motor centre for the larynx is in the bulb. This subject he had discussed in a paper read at the last meeting of the Association, and had gone over the whole subject. There are but two forms of laryngeal paralysis. We have no other forms.

Dr. Mackenzie: The case corresponds clinically with other cases of bulbar disease, and cannot be explained on the ground that it is a neuritis, especially of the trifacial, unless the nerve is distributed to the back of the neck and the lower extremities as well as to throat and larynx. He thought that the last speaker had misunderstood, or failed to hear the history of the case, and requested him to look over it carefully, and he would find the diagnosis of neuritis untenable.

Look Beyond the Nose. In this paper Dr. S. Solis-Cohen made a plea for the broader view of the cause of diseases in the nasal chambers and their relation to general symptoms. Cases were reported showing mistakes in diagnosis, where headache and other symptoms, not relieved by operation, were promptly cured by general treatment.

Dr. Roe said that headache always indicates that something abnormal is going on; but when any man attempts to ascribe all headaches to one source, he also is abnormal. The causes are varied. Of two cases, both presenting affections of the nose or naso-pharynx, and treated precisely alike, one will be entirely relieved, the other will not be cured until he has appropriate constitutional treatment for the concurrent disorder. He cited a case of his own. An operation had relieved a headache which had been troubling the patient for three or four years. There was marked pressure between

the middle turbinated bone and the septum, which he had relieved. The facts of Dr. Cohen's paper go without the saying.

Dr. Jarvis agreed with the last speaker, that we could not account for the fact that nasal obstruction is attended by nervous symptoms, such as headache, in some persons and not in others. While reading Stanley's account of the expedition in Africa, he noticed that the blacks were quite unmindful of even serious wounds, and seemed to recover with little disturbance of health. This led him to formulate a theory that might explain the problem stated above. The ancestors of the blacks had been accustomed to being wounded, and to have their flesh cut or scratched in going through the undergrowth, so that after a number of generations the nervous system became less irritable. In civilized life, among the higher classes, protected as they are from physical injury, the nervous system becomes more susceptible. He has known a slight amount of nasal obstruction in a brain-worker to produce a great deal of distress, headache, etc. The same lesion might be entirely unattended by nervous symptoms among the lower classes. The difference consists in the increased susceptibility of the nervous system to peripheral impressions.

Dr. Bosworth : It seems like an indictment of the members to imply that they do not look beyond the nose. As competent specialists we all do look beyond the nose.

An Instrument for Removing Glandular Hypertrophies from the Tongue. The presentation of instruments being in order, Dr. Roe exhibited a guillotine, made on the principle of the tonsillotome, for removing hypertrophied adenoid tissue from the dorsum of the tongue.

Dr. Bosworth said that there was danger of cutting off the epiglottis in unskilful hands ; and several Fellows declared that they had never seen a case that would

require the employment of such an instrument, and said that hypertrophied glandular tissue at the base of the tongue was a very rare condition.

Dr. Roe said that the accident need not occur if ordinary care be employed in using the instrument.

Wire-Loop Curette for Removing Adenoid New Growths from the Pharynx. Dr. Holden, of Newark, exhibited an instrument consisting of a flexible wire-loop fixed in a handle, the loop being sharp upon its inner or concave side, dull upon its convex side. He has found it very useful in removing vegetation from the pharynx, acting very much like the finger nail.

Dr. Delavan presented several instruments designed for the removal of adenoid hypertrophies or fibroids from the pharynx. One was a loop-shaped steel instrument, cutting on the inner side, the other being a sharp spoon, both being employed preliminary to using the forceps for the removal of these growths in young adults.

A New Operation for Deviation of the Nasal Septum. This was described by Dr. Morris Asch, of New York, who used (1) a peculiarly shaped pair of forceps or scissors, with short, curved blades, one of which is sharp and the other dull ; (2) a gouge ; (3) Adams's forceps ; and (4) a triangular splint of tin, cut to adapt itself to the cartilage of the section. In performing the operation, the patient is etherized, the adhesions between the septum and turbinated body, when such exist, are broken up by the curved gouge. The blunt edge of the scissors is inserted into the obstructed nostril and the cutting blade into the other. A crucial incision is then made as near as possible at right angles to the point of greatest convexity. The gouge is then inserted into the obstructed nostril. The segments made by the incision are pushed into the opposite one and the pressure continued until they are broken at their base and the resiliency of the septum destroyed. On this point

depends the success of the operation, for unless the fracture of these segments is assured, the resiliency of the cartilage will not be overcome, and the operation will fail. The septum is then to be straightened with the Adams or other strong forceps and the hæmorrhage checked before proceeding farther, which is usually accomplished by a spray of ice water, though sometimes tamponing may be required. The nostril having been cleansed, the straightened septum is then held in position by the splint, previously wrapped with absorbent cotton, moistened in a solution of bichloride of mercury (1-5,000), and the nostril packed with gauze or absorbent cotton, moistened with the same. This should be done thoroughly or hæmorrhage will follow. The splint is usually allowed to remain four days without being disturbed, and then removed; and after cleansing and disinfecting the parts, the splint and tampon are then reapplied, the parts being straightened, if necessary, with the forceps. The treatment lasts from three to five weeks. If bony deviation is found to exist behind the cartilaginous one, it can be easily removed with the saw or electric trephine. Six cases were appended to the paper.

Dr. Mulhall, of St. Louis, remarked that he came from the city of Dr. Steele, who was the inventor of the instrument for treating these cases, known as Steele's forceps, which he used in fifteen or twenty cases. Although not entirely pleased with it, he approved of the plan submitted by the lecturer, of restoring the parts with a single incision. Steele's forceps makes six cuts. He had often had persistent perforation at the centre of the crucial incision, and should give Dr. Asch's instrument a trial.

Dr. Jarvis said that in order to prevent the perforation above mentioned, after operation, he had modified the forceps so that while the six incisions were made, an island in the centre was left untouched. With this he had never had perforation

resulting. In order to keep the channel open he had discarded plugs, and resorted to an external nasal splint which he had devised some time ago.

Dr. Ingals said that the principle of the instrument was not new. He had learned at college to make two parallel oblique incisions through the septum, so as to make it movable and place it in proper position. In nineteen out of twenty of these cases there is excess of tissue, and he advocated the removal of a triangular piece between the incisions, so as to permit the septum to fall into position. Where there is no hypertrophy, he would prefer to use a small trephine, making three or four perforations, and then the septum can readily be moved into position and kept there with some sort of splint. His own practice was to pack the affected side with absorbent, antiseptic gauze, leaving the opposite nostril free. The dressing is changed in twenty-four hours by the patient and a douche used, before returning to the office. He then introduces a flattened tube of gutta percha, fitted to the nostril; he prefers gutta percha to soft rubber or ivory because it does not swell and cause pressure. The gutta percha may be wrapped around with gauze if desired. It is easily moulded, when heated, to any shape.

Dr. Roe said that where the deviation was limited to the cartilaginous septum, he was in the habit of dividing it with a bistoury in the direction of greatest convexity, then forcing it into position with Adams's forceps, or a similar instrument, rather over-correcting the deformity. When the deviation exists also in the bone, he breaks it up with the forceps, and uses a gauze antiseptic plug in the affected side. In this way he almost always had good results. When an exostosis exists it should be removed.

Dr. Bosworth complimented Dr. Asch upon bringing out such an ingenious instrument, which not only corrects a vertical displacement, but a lateral one as well.

Dr. Mackenzie said that with Steele's instrument he failed to cut through the septum. He had used a modification of these forceps made in Philadelphia, which had answered his purpose fully. He approved Dr. Roe's suggestion to remove a portion of the cartilaginous septum when hypertrophied, in order to get a permanent result. His cases did not bear plugging of the nostril, and he considered it unnecessary. The septum cannot be kept in place by pressure. If anything of the kind is used, it should be cotton wet with glycerine or vaseline. With regard to the hard plug, he had seen unilateral convulsions caused by an ivory plug, this was repeated several times. He considered the after-treatment the most important.

Dr. Langmaid said that it did not matter so much what means were used to break the septum, the object of treatment is to prevent the recurrence of the deformity. He would emphasize the fact that after the operation the septum must remain in position of itself without pressure. He preferred a small black rubber nipple, wrapped with cotton, for a plug, and adapted to the shape and size of the nostril. He approved of Dr. Mulhall's suggestion, that patients should occasionally introduce a finger into the nose and push the septum over where there is a tendency to recurrence.

Dr. Jarvis said regarding the external nasal splint, although he had used it formerly in many cases, he had not used it lately. He now uses a new crown drill, with which he pulverizes the bony obstruction, guided by transfixion needles so as not to perforate the septum. In this way he secures enough room for the septum to fall into good position, and give good flow of air through the nostril.

Dr. Bosworth considered it unjustifiable to remove an organ of important functions simply for the purpose of admitting more air into the nose.

Dr. Mulhall defended Steele's forceps against the charge that they would not go through the septum. He had not found this

difficulty where there was no hypertrophy. Where there was this complication, he reduced the hypertrophy first. While there was a tendency to return after the operation, he had never seen it so decided as at first—never complete closure.

Dr. Ingals said that the resiliency of the septum must be gotten rid of before the operation is finished; after this, the treatment is very simple. He has had patients wearing a plug for six weeks. Where there is great thickening, he advised running a small trephine through it several times, without perforation, until it can be easily pushed over to the other side.

Dr. Mackenzie said, in reply, to Dr. Mulhall, that he referred to deformed, and not thickened septa; Steele's forceps would not cut through ordinary thick paper, whereas those he referred to would cut six thicknesses of chamois skin.

Dr. Daly said that he had not experienced any difficulty with Steele's forceps. He does not stop with one incision, but cuts the septum in several places. The object is to break up the cartilage, it is not necessary to perforate the septum.

Dr. Asch, in closing the discussion, said that in the paper he had declared that the success of the operation depends upon breaking down the resiliency of the septum; this being done, the splint is introduced. If it is plugged lightly with cotton, there is no trouble whatever. With regard to his instrument, he had been led to it by his failure with Steele's. In Jarvis's plan, the resiliency of the cartilage is not destroyed, and the deformity will return. He had never had septic symptoms after the use of the plug.

Dr. Daly described his method of plugging the nostril with absorbent cotton, wrapped spirally with cotton thread, so that the entire plug could be easily removed.

The President remarked that the whole discussion turned upon the necessity of overcoming the resiliency of the septum in order to secure a permanent result. This point he had already insisted upon in a

paper read before the Association some seven years ago.

Dr. Holden referred to a case of a young lady, upon whom repeated operations had been done without entirely overcoming the deformity. The septum in this case was then movable and crackled like parchment under the finger. The last operation with Steele's forceps, followed by ivory plug, had straightened the septum, but had left an ugly excrescence in the nostril, which he proposed to remove with the drill.

A Case of Fibro-Myxomatous Tumor Taken from the Naso-Pharynx of a Child Six years of Age. Dr. Alexander W. McCoy, of Philadelphia, stated that this was the first case that had come under his attention in so young a child, although he had seen a polypus in a child under one year of age. Myxoma in the nasal chambers presupposed catarrhal inflammation, and this is why it is so rare in childhood, because few have had chronic inflammation of sufficient duration to develop the pathological changes necessary for the growth of polypi. The tumor in this case filled the nasopharyngeal region, but did not come below the soft palate. The attachment was about half an inch in diameter, the growth springing from the free surface of the vomer. It was removed by the galvano-cautery snare; the wire was passed through the nostril and around the base of the growth, and the pedicle cut through. There was trifling amount of hæmorrhage. Recovery was prompt and complete. The growth, upon microscopic examination, possessed the characters of a fibro-myxoma.

The President said that he had previously published the notes of two cases of myxoma in children. They occurred in the same family, in a brother and sister, one four years of age, the other six. He removed both with the cold-wire snare. Morell Mackenzie did not meet with a case under the age of sixteen years. Voltolini reported a case of polypus in a very young child; such instances are apt to turn out to be simply hypertrophies.

Dr. Swaine had seen a case in a child eight years of age of fibro-myxoma, just before leaving Germany; he did not know the outcome of it.

A Case of Fibro-Sarcoma of the Right Nasal Fossa with Unusual Clinical History.

Dr. Chas. H. Knight reported this case accompanied by a specimen. The growth in this case had its origin in the nasal cavity. Baker, forty-two years. Family and private health good. Twelve years previously he received a blow upon the bridge of the nose, to which he attributed his malady. For two years he had had nasal obstruction, gradually increasing; frequent sneezing; constant frontal headache. Disposition became irritable, and used liquor to excess contrary to previous habit. No hæmorrhage, until two months ago, when he expelled from the right anterior naris masses of bloody tissue, and about the same time expelled a fleshy mass as large as a robin's egg from the posterior nares. The right eye became closed by œdematous swelling of lids and infra-orbital region. The right nasal chamber was found completely filled with a soft vascular and very sensitive mass resembling an old myxoma. Part of the growth was snared off, and profuse hæmorrhage resulted. The growth was rapidly reproduced in the next few days.

The patient then went to the hospital, where Dr. Weir performed Chassaignac's operation. Part of the growth was curetted off, when it was found that it involved the ethmoidal and sphenoidal cells, and the operation was carried no further. The patient made a good recovery from the operation; but the growth redeveloped in six weeks, and involved the face. Three months after the operation, the patient in a delirious condition, tore out a portion of the tumor by putting his fingers into his mouth and dragging out an irregular mass, which was from the naso-pharynx. The rush of blood was very great, but ceased spontaneously before the arrival of the physician. The patient was exhausted,

and died five hours later. No autopsy.

The paper was largely devoted to a consideration of the literature of the subject, and the methods of operation. The lecturer favored a radical operation such as Maissonneuve's, when the growth shows any tendency to malignancy. The theory of traumatism was declared insufficient to cause the morbid action. It alone is not capable of creating malignancy. Microscopical examination of the specimen showed the characters of fibro-myxoma.

Dr. Bosworth deprecated severe measures. The only case of recovery from sarcoma that he knew of was one in which severe measures could not be borne. It was reported at the meeting of the American Medical Association several years ago. Butlin says that it is at first a purely local disease. The old operations are unnecessary. At the present day all parts of the nose are accessible without such severe operations, and the growth can be snared off. In carcinoma no treatment is of service.

Dr. Mulhall reported a case of small-celled sarcoma filling both nostrils. The case also had some interest in connection with the question of the origin of the disease from injury. The man was injured on the railroad about a year before the disease appeared. When first seen a mass of soft material projected from both nostrils; it bled easily. The galvano-cautery was used to clear one nostril after several sittings; but he became tired of treatment, took to the use of morphine, and died in four months. The disease lasted about a year.

Dr. Knight said, with regard to radical measures, he would not advocate any except the operation of Maissonneuve.

Adenoid Tissue in the Naso-Pharynx and the Pharynx. A Preliminary Report on the Development and Early History. In this paper Dr. H. L. Swain, of New Haven, Conn., considered the adenoid tissue in this locality as a whole; that is, the ring of tissue formed by the pharynx tonsil above;

next the tissue in the region of the tubes on either side, then the lateral columns of the pharynx, the faucial tonsils, and, last of all, the lingual tonsil. This ring of tissue is right at the junction of the tissues formed by the ectoderm and the entoderm of the embryo, and is itself formed by the participation of the entoderm as motive principle and the mesoderm as origin of the cell infiltration.

In studying the development, it was found that the pharynx tonsil was the earliest to begin, as it is the oldest gland in the comparative history, being found in the lowest form of animals. Next in age were found the faucial tonsils; while the youngest member of the group, or at least the latest to form, was the lingual tonsil. Thus there is a physiological basis to observed phenomena of early atrophy of pharynx and late endurance of the lingual tonsil. The beginning of all these different portions of the ring of adenoid tissue in the embryo was alike, not varying as does the tissue. The bursa pharyngea of Luschka seems to have a somewhat inconsistent embryonic existence and must not be confounded with the recessus pharyngeus medius, which is of more frequent occurrence in the well-developed organ.

The constant appearance of follicles in all parts of this tissue is a normal phenomenon, but is, unquestionably, as observed in the lingual tonsil, influenced by pathological changes. That is, disease favors an earlier appearance of the follicles, and causes an increase in their size and number. The conglobate glands in the pharynx tonsil possess no hollow spot.

In considering the function of the adenoid tissue, many views were spoken of, but credence given to a two-fold purpose which this tissue fulfils, namely, an organ for the formation of leucocytes, where amœboid cells, by virtue of their immigration to the surface, come into a position to meet micro-organisms and protect the system from their influence by destroying them. Secondly, there seems to be a direct relation

between the number of leucocytes present in this adenoid tissue and the demand of the rest of the system for those cells ; for, in cases of long-continued purulent process, there is a great diminution in their number. From the first we may deduce reasons for the larger development of adenoid tissue in man and in certain animals ; from the second, an explanation of the atrophy of this tissue in many observed cases.

Dr. Bosworth complimented the author upon his paper, as the function and pathology of the lymphatic structures of the nose and throat are now occupying considerable attention. The suggestion by Scanes Spicer, that the tonsils are placed in the throat to absorb excess of fluid, does not amount to the dignity of a physiological theory. Killian's view was that this adenoid tissue is placed here to destroy micro-organisms, but they might just as well be looked upon as traps for micro-organisms where they develop. A very interesting question in catarrh is, Where does all the fluid come from ?

Supplemental Report on Cartilaginous Tumors of the Larynx and Warty Growths in the Nose. By Dr. E. Fletcher Ingals, of Chicago. The first case had been reported to this Association two years ago, when still under treatment by applications of chromic acid full strength for cartilaginous growths just beneath the vocal cords. Although a practical cure seemed to have been obtained, the patient afterwards returned with slight thickening of the base of the growth, which required several subsequent applications. During the past year there has been no recurrence. At present the mucous membrane appears healthy ; no cicatrix. The acid seems to have caused absorption rather than destruction. At the last meeting, a case of similar growth in the nose was reported, which resisted chromic acid, nitric acid, galvano-cautery and other means. Subsequent applications of tincture of thuja occidentalis upon a pledget of cotton (twice daily), with internal administration of drachm doses three times each

day, was followed by improvement. Occasional applications of chromic acid were also made about once a week. This was followed by complete disappearance of the warty growths.

Dr. Bosworth referred to a case seen some months ago in a child three months of age. It was a broad, papillary growth on the tongue and palate. He applied thuja, but without result. The growth was afterwards completely destroyed with acetic acid. They were like warts on the skin anywhere.

Dr. Mulhall considered that some confusion existed between soft growths and papillomata. A paper published some time since stated that the writer had seen several hundred cases of warty growth. The diagnosis can only be made with the microscope. He had individually seen only a single case of papilloma of the nose. It sprang from the anterior end of the middle turbinated bone, and looked exactly like a bunch of grapes.

Dr. Jarvis advocated the use of chromic acid in removing papillomatous tissue, as the best caustic. He agreed with the last speaker that papilloma of the nose was rare ; he had seen only two cases.

Dr. MacCoy had treated three cases of warty growths from the vestibule with the galvano-cautery.

A Case of Unilateral Paralysis of the Abductors of the Larynx ; the Result of an Attack of Bulbar Disease ; with Unusual Symptom. Dr. Francke Bosworth, of New York, reported the case of a gentleman, who had chronic suppurative inflammation of the left antrum following ulceration around a tooth which had been extracted nine months before coming under observation. He had an attack during the night of dizziness and nausea followed by right hemiplegia, with lateral loss of taste, and difficulty in deglutition. This attack passed away, and four months later, when seen, he considered himself completely recovered from the attack. No paralysis of extremities. Right vocal cord was motionless,

however. This was due to some permanent change in the centre in the medulla governing the motions of the abductor muscle of the right side. A second case was referred to, which had been pronounced one of paralysis of the left abductor due to aneurism. Upon examination, a partial ankylosis of the crico-arytenoid was discovered, which fully accounted for the symptoms present. Here was a case pronounced one of paralysis by a very competent observer, and yet one which should not be regarded as either extrinsic, myopathic or any other form of paralysis.

An inquiry from Dr. Westbrook, if the suddenness of onset, and the extent of motor paralysis and short duration would not exclude the medulla as the site of the lesion, and favor the view of embolism involving the capsule, brought the reply that there was no doubt in the reader's mind that the case was one of bulbar paralysis, which might have been due to a clot or some lesion involving the base of the brain or the cerebellum.

On the Early Diagnosis of Malignant Disease of the Larynx. A paper on this subject was read by Dr. D. Bryson Delavan, of New York, who dwelt upon the great importance of an early diagnosis of carcinoma, and the necessity of prompt recognition of the disease. The diagnosis in many cases is rendered difficult by complications. Thus, pulmonary phthisis may be in active progress, and lead to the diagnosis of tubercular laryngitis. The appearances of syphiloma of the larynx are often like those of cancer, and the temporary improvement, often seen under the influence of iodide of potassium, still further misleads the observer. On the other hand, syphilis of the larynx is often pronounced cancer, and serious operations advised. From a careful review, he believed that three points in diagnosis may be useful early in the case :

(1) Thickening of the mucous membrane, with marked loss of motion in the neighborhood of such thickening, implies

an infiltration of the muscles which, generally speaking, is due to malignant disease. An apparent paralysis of one side of the larynx, associated with thickening upon the same side, should always call for the exercise of extreme caution in the matter of prognosis.

(2) As the result of numerous investigations made by many observers during the past two years, it is generally admitted that, of new growths of the larynx apparently papillomatous, those, the bases of which are not surrounded by a zone of inflammation, are probably benign ; while those which are encircled by a ring of reddened, infiltrated membrane are almost certain to be malignant. The truth of this proposition has been verified in several instances by the writer.

Trans-illumination of the larynx, first suggested by Voltolini, has been studied during the past year by several observers. While by the use of the electric light, applied to the exterior of the larynx, the writer has found it possible to gain tolerably satisfactory results in causing the light to penetrate the walls of the larynx, it would hardly be possible by this method to recognize the presence of an abnormal thickening, which was not already sufficiently well-developed, to be visible to the eye by the ordinary intra-laryngeal demonstration. As a means of recognizing the presence of a new-growth of recent origin and of small extent, this method is, at present, of doubtful value. For the purpose, however, of demonstrating the relative density of an enlargement of appreciable size, trans-illumination of the larynx is a method of considerable importance, and, even in cases of the class first mentioned, it may occasionally be found useful.

DRS. MACKENZIE, DALY, INGALS, BOSWORTH, HOLDEN, ASCH, MULHALL, SWAIN, LANGMAID, SEILER, and DELAVAN participated in a lengthy discussion, in which there was little disposition to accept any diagnostic character of early

carcinoma. Dr. Langmaid mentioned a zone of infiltration and redness of the tissue around the growth as an early indication of its malignant nature. The treatment was thoroughly discussed.

A Case of Stricture of the Œsophagus from Interstitial Thickening of its Walls.

Dr. John O. Roe, of Rochester, reported the case of a woman, fifty-eight years of age, free from syphilitic history. The patient died from exhaustion. On post-mortem examination, ankylosis of the arytenoid articulations was found, which had been diagnosticated during life; also a marked rigidity of the wall of the larynx due to general thickening of the tissues throughout the larynx. No indication of tubercle. Several constrictions were found in the œsophagus, only admitting a lead pencil by using force. Microscopic examination of the thickened walls showed a connective tissue infiltration, the muscular fibrillæ being degenerated and replaced by this connective tissue formation. It was, therefore, a pseudo-hypertrophy of the muscular wall, but a real hypertrophy of the connective tissue. The new formation was attributed to chronic inflammation analogous to that in the lungs in fibroid phthisis.

Dr. Langmaid inquired if the lecturer had tried the introduction of a permanent tube in the œsophagus?

Dr. Roe: It was tried, but the patient could not endure it.

Dr. Mulhall: Was ankylosis of crico-arytenoid articulation first detected post-mortem?

Dr. Roe: No, it was discovered by the laryngoscope during life. The patient spoke in a monotone without modulation of voice, just as in paralysis of the posterior crico-arytenoid muscle.

Dr. Mulhall: Was there no paralysis?

Dr. Roe: Yes, from pressure.

Dr. Bosworth said there could not be a better illustration of the fact that all cases of immobility of portions of the larynx are not always due to paralysis; here there

was ankylosis. The pressure upon the recurrent laryngeal nerve had nothing to do with the paralysis.

Dr. Roe stated that he had said that the ankylosis might have antedated the paralysis, but did not say that it had.

Dr. Mulhall said that he had made two post-mortem examinations of malignant disease involving the recurrent laryngeal nerve, and in both cases the larynx was in the cadaveric position. In neither case was there the least ankylosis of the crico-arytenoid joint, although it had been immobilized for months. This is why he asked the question. Does Dr. Roe think that the ankylosis of this joint was the cause of the appearance in the larynx?

Dr. Roe: No. There was sufficient infiltration of tissues in the larynx to account for it.

Dr. Mulhall inquired if he thought that an abductor paralysis of eight or nine months, with very little motion, if any, in this joint, would produce ankylosis?

Dr. Bosworth: A case was reported by Lefferts, in which, paralysis was due to a gumma; months afterward the gumma was absorbed, and the mobility of the joint was restored. Why should there be loss of motion?

Dr. Roe: There was every evidence in this case, that there was complete paralysis of the larynx, so that this pressure upon the laryngeal nerve, and this infiltration of tissue occurred before ankylosis took place. The paralysis of the posterior crico-arytenoid might have taken place first before complete paralysis. In another case with paralysis of both posterior crico-arytenoids, post-mortem examination showed that the original cause was found to be a clot in the brain.

Dr. Mulhall: Was the patent iodized?

Dr. Roe: Yes. She had been treated by iodide of potassium; but when she came under observation, she was dying from exhaustion, and only lived a few days.*

* Reprinted from the *Boston Medical and Surgical Journal*.

Current Literature.

The Surgical Treatment of Cough.—By Dr. J. W. Gleitsmann, New York. The following list embraces those affections which have thus far received but little attention as factors in the causation of cough; I mention them in the order of frequency with which they induce this symptom. They are:

1. Adenoid vegetations of the naso-pharynx.
2. Hypertrophic rhinitis, deviations and exostoses of the septum, mucous polypi of the nose.
3. Hypertrophy and chronic affections of the faucial tonsils.
4. Granular pharyngitis.
5. Hypertrophy of the tonsil of the tongue.

If we desire to express in numbers the relative frequency of cough in the affections just mentioned, we may say that it occurs in from two to five per cent. of all cases, wherein my experience agrees with that of other observers. Schaeffer, however, saw hypertrophy of the faucial tonsils produce cough more frequently than granular pharyngitis, his statistics differing from mine in this respect.

Hypertrophy of the tonsil of the pharynx and the adenoid vegetations of the naso-pharynx I operate on with Löwenberg's forceps, an instrument which has undergone many modifications. The largest is intended for adults, the second I prefer for children, and the third was made for an operation on a child two months old. Although it can be performed on sensible and older children without narcosis, I have nevertheless frequently used anæsthetics during the last few years, as a complete removal of the vegetations at one sitting is thereby made possible. The diseased tissue should be removed as completely as possible, and the patient kept under observation for about three or four weeks afterward, otherwise the symptoms may return.

Nasal cough, no matter whether it occurs spontaneously or follows contact with a probe, is always an abnormal reflex, the natural reaction of the nose to irritation being sneezing. It is difficult, however, to decide at times whether the cough is induced from the nose or not. If we can produce it experimentally—for instance, with the probe—or if we can cut short an attack with cocaine, the nasal origin of the neurosis is proven. The negative result, however, of an application of cocaine does not prove the contrary, as Schech correctly remarks, because there may be several reflex zones, or the solution may have been too weak to suppress the reflex, or the pathological reflex could not be checked any more. In cases in which the diagnosis cannot be made with certainty the conscientious physician will not undertake operative procedures which are not fully justified—a rule which at present is frequently disregarded. When organic changes have taken place or the diagnosis is readily made, operative interference is indicated.

As regards the various affections of the nose, in the course of which cough is observed, we can destroy hypertrophies of the anterior turbinated bones with caustics, and particularly with the galvano-cautery. Removal of posterior hypertrophies is more difficult, and is best performed with a snare, which, properly curved, is introduced from in front into the naso-pharynx, the hypertrophy is seized and snared off. When the cold wire of the Jarvis snare is used, the operation must be extended over one or two hours, as the loop can only be tightened very gradually in order to avoid hæmorrhage. Not even the greatest care, however, can sometimes avoid such an unpleasant complication. This circumstance, the length of time required, and the difficulty of preserving the original shape of the snare after introduction into the nasal cavity, on account of the softness of the platinum wire, led me to the construction of my iridium-platinum wire,

which I now use exclusively, in connection with Schech's handle.

The instruments necessary for trephining exostoses of the septum are a good battery, a motor, a handpiece, and trephines of various sizes and shapes. In January of last year I began to operate on suitable cases of exostosis with Bosworth's saw, and, besides a larger number of ordinary shape, removed some of unusual size. For the removal of incompletely detached or wedged-in pieces of bone I use my nasal bone-forceps, which occupies but little space, yet permits of the exertion of great force.

In regard to the next two affections, the diseases of the tonsils and granular pharyngitis, I can be brief, as every physician at present undertakes their treatment. I would call attention to the fact, however, that not every tonsil must be considered normal which is not hypertrophic, or which on inspection shows nothing abnormal. When the tonsil is drawn out with proper instruments, or, in retching, the median surface becomes visible and a good view of it is obtained; we may then discover in some cases affections of the lacunæ with deposits of concretions, sometimes also of leptothrix, which can produce very disagreeable reflex symptoms and also cough. Their complete removal and, if necessary, the destruction of the tonsil with the galvano-cautery is imperatively indicated. The latter instrument I use almost exclusively in granular pharyngitis, though we must not forget that the lateral pharyngeal bands, which extend parallel to and also behind the arcus palato-pharyngeus, generally give the patients more trouble than a few granulations at the middle of the posterior wall of the pharynx.

According to my experience, especially that of late years, hypertrophy of the lymphatic tissue at the base of the tongue—also called the tonsil of the tongue, and by some authors the fourth tonsil—frequently gives rise to vague pharyngeal complaints, the cause of which is often

not recognized. A careful examination might trace the complaints of many patients, who have been treated for chronic pharyngitis or paræsthesia or hyperæsthesia with unsatisfactory result, to this source, whereupon proper treatment will effect a cure.

For destroying hypertrophic tissue I mainly use three remedies. They are solutions of iodine-glycerine of varying strength applied with a cotton-carrier, nitrate of silver melted upon probes of the proper curvature, and the galvano-cautery. The last mentioned may be used in two ways. The hypertrophy can be made to disappear by scarifications with the proper electrodes, or, if it is confined to a small space and the tonsil is divided into two parts by a longitudinal depression, the attempt may be made to remove it with the snare. For this purpose I use my iridium-platinum wire. When the whole mass can be seized and snared off, the same result is obtained with one operation which otherwise would require repeated applications of the galvano-cautery.—*Brooklyn Medical Journal.*

On the Employment of Cold Baths in the Treatment of Pneumonia.—By M. Barth (*L'Union Médicale*, July 3, 1890). It has for a long time been considered that the effect of the cold bath was the direct abstraction of caloric. This certainly is one of the most important, and the most readily apprehended, but it is not the only effect. Its action is first upon the circulatory system. During the immersion the vessels of the surface contract, the blood flows towards the viscera; its tension is augmented, and with it the work of the heart. After the bath an energetic reaction takes place, the blood flows back to the superficial vessels, and leaves the visceral cavities. The nervous system is energetically stimulated; the brain becomes active, delirium ceases, the pulse increases in force, respiration becomes more regular. Secretion is promoted,

saliva and perspiration become abundant ; but it is more especially upon the urine that the cold bath exerts any influence, even albumen, if it has existed, disappears. The action of the cold bath is not merely antithermic, but is actively therapeutic.—*Provincial Medical Journal*.

Prevention of Pulmonary Consumption.

—Dr. Paul H. Kretzschmar enumerates certain functional and structural changes which, when found existing in young subjects, indicate serious danger of future tubercular infection. In line of their importance these deranged conditions of the human system are :

1. Those anatomical changes in the formation of the chest which help to present what is known as the phthisical habitus.
2. The fact that the subject is and always has been a small feeder.
3. The fact that, during the age of puberty, the patient has suffered from palpitation of the heart.
4. The fact that, at the same time, and frequently for years afterward, the patient has been suffering from epistaxis (nose bleeding).

If these abnormal conditions, or part of them, are found in subjects whose family histories raise the sign of danger, it is necessary to use such means as will diminish the danger of future infection. Medication is of no value, but a transfer of the threatened subject to a proper climate will do much to prevent the future development of pulmonary consumption. The author is thoroughly convinced that certain elevated regions enjoy comparative immunity from phthisis, and that a removal of those cases which warrant an unfavorable prognosis regarding the development of consumption to such parts, would save many lives.—*Brooklyn Medical Journal*.

Treatment of Diphtheria.—On the ground of thirty years' experience with the disease, Dr. C. G. Slagle, of Minneapolis,

recommends the following treatment, which he has employed with success for the last three years : *R.* Calomel, grs. xii ; soda carbonate, grs. xxxvi, ft. chart. no. xii (or half this if young child). Sig. "A powder every two hours." To be followed (when all used) by *ol. ricini* 3j, *ol. terebinth.* 3j. And every alternate hour and until the case is fairly convalescing, give a teaspoonful of a saturated solution of sulphite of sodium ; if the case is a bad one, direct a gargle or spray of the same to the throat every two hours.—*Northwestern Lancet*.

Potassium Tellurate in the Night-Sweats of Phthisis.

—In the *Wiener Klinische Wochenschrift* for June 5, Dr. Edmund Neusser relates his experience with potassium tellurate as a remedy for the night-sweats of consumptives. He used it in the form of a pill, giving at first .02 gramme (about a third of a grain) at a dose. In most of his cases this proved sufficient, but a few patients began to sweat again after a time, and with them he doubled the dose, generally with good results. In but few instances were any toxic effects observed, even with doses of a grain ; it was only after their prolonged use that anything of the kind occurred, and then the symptoms were only those of moderate disturbance of digestion. An objection to the employment of the remedy, however, is the fact that it imparts an intense garlicky odor to the breath, but generally this is not perceived by the patient, although two of the patients complained of a sulphurous or camphoraceous odor of the eructations.—*New York Medical Journal*, July 5, 1890.

Tropho-Neuroses of the Oral Cavity.

—Dr. Frank Lydston states that his attention was first called to the possible dependence of syphilitic lesions upon trophoneuroses by a series of cases of necrosis of the maxilla, alveolar processes, palate and bones of the nose, occurring in cases of

tertiary syphilis. In studying these cases he was led to pursue the line of thought a little further, and found that evidences of the dependence of syphilitic phenomena upon organic or functional disturbances of the sympathetic system are quite positively manifested here and there along the whole line of morbid phenomena developed in the course of the disease. In the late or sequelar syphilides there is a special tendency to disturbances of a tropho-neurotic character. It would appear that syphilitic infection not only has a peculiar affinity for the sympathetic nervous system, but that this affinity is particularly marked in the upper or cervical portion of the sympathetic. All through the disease the proportion of lesions about the head, face and mouth, is relatively much larger even under the best treatment than in other portions of the body. The parts supplied by the fifth cranial nerve appear to be particularly susceptible. There are few cases indeed, no matter how thoroughly they may be treated, that are not affected at one time or another with lesions of the lips, inner surface of the cheeks, tongue, throat and scalp. Cases are frequently met with in which the initiatory and active periods of the disease have been passed through without serious trouble, when suddenly and without warning serious destruction of the nasal, palatal, or maxillary bones are manifest. The author has long been impressed by the peculiar course of some of the lesions of late syphilis, particularly those affecting the head, face, and oral cavity, and it has seemed to him that the destructive effects exerted by the morbid process upon the bony tissue is greatly disproportionate to the objective and subjective phenomena which precede the actual destruction.—*Medical Age*.

The Breath in Pædiatry.—Dr. L. Starr, of Philadelphia, ("Annals of Gyn. and Pæd.") claims that the persistent presence of an odor in the breath of children is abnormal and indicates disease. Any mor-

bid systemic condition which prevents elimination of metamorphosed nitrogenized tissue through the intestinal mucous membrane, or retards the passage of decomposing detritus along the bowel, will cause offensive breath. Local conditions, like decayed teeth, nasal and maxillary bone caries, buccal, nasal, laryngeal, and tracheal mucous membrane ulceration, as well as bronchial tube ulceration and cheek gangrene, may cause it. Lead, mercurial and arsenic poisoning may cause it. The odorous breaths may be rudely divided into sour, catarrhal, foetid, gangrenous, ammoniacal and stercoraceous. Sour breath is present especially when there is acid fermentation. In chronic vomiting, chronic entero-colitis and thrush, there is usually an intensely acid odor. In chronic pharyngeal catarrh there is a "heavy" breath. If the catarrh invade the follicles, the "heavy breath" has in addition an offensive, penetrating odor resembling decayed cheese, which is worse after sleeping. At the outset of acute gastric catarrh the breath is tainted. It may have a vinous odor, at other times a sweetish. Sometimes it has the odor observable in the breath after the administration of ether. Later the breath may have a sulphuretted hydrogen odor, especially in older children on a solid albuminoid diet. The "feverish" breath found in diseases of high temperature has a heavy, sweetish smell. It is very marked and rapid in appearance in scarlatina. In chronic intestinal catarrh the odor is fæcal in character. Nasal catarrh causes a heavy odor. In stomatitis there is a heavy foetid breath. In tissue necrosis the breath may have a garlicky odor. Ammoniacal breath is found only in uræmia. Stercoraceous breath is found in cases of intussusception and fæcal tumor.—*Medical Standard*.

Menthol in Diseases of the Air-Passages.—Dr. S. S. Bishop says that it is advantageous to prescribe inhalations of menthol for patients who take cold easily,

so that they can employ the treatment at home whenever a coryza is coming on. A drachm or two of the crystals in a wide-mouth vial, with a metallic screw-cap, or a glass tube, is a convenient device. A pledget of cotton should be pressed into the vial to prevent the menthol from escaping and coming in contact with the nose, for it occasions smarting sensations wherever it touches the nostrils. If a large glass tube is used, both ends should be plugged with cotton wool. As menthol does not melt at a temperature below 98° F., it can be carried in the pocket for ready and frequent use. When not in use, however, it should be tightly corked to prevent evaporation. In prescribing it for patients to use in atomizers, it is best to use a solution not stronger than five or ten per cent. in oil. Albolen is preferable to fluid vaselin, for the latter alone often proves irritating to the mucous membrane.

In chronic hypertrophic rhinitis, with a foul-smelling discharge, menthol is sufficiently antiseptic and alterative to lessen the amount of discharge and to banish the odor. The peppermint aroma is usually agreeable, and more especially so when it supplants the stench of decomposition. In atrophic catarrh the stimulating properties of the drug, combined with the emollient and protective qualities of albolen, afford a means of speedy improvement.

In laryngitis not dependent on a rheumatic conditions menthol proves valuable. Even in rheumatic laryngitis it is an efficient adjunct to salicylate of sodium, iodide of potassium, etc. In simple acute laryngitis, if used in the early stage, it will relieve as it does in coryza; but the spray is the most effectual form in which to use it. When the soreness of the larynx and trachea, and hoarseness appear, a few inhalations of the spray often nip the attack in the bud. It relieves the hoarseness, and imparts a smooth, reed-like *timbre* to the voice. In advanced cases several inhalations of the spray

should be used in the course of a day, and a continuous effect is often advantageous. This can be secured by keeping a saucer heated in the patient's room, and occasionally dropping a few of the crystals on it during the day and night. They melt readily at a low temperature, and fill the atmosphere with their penetrating fumes.

In whooping-cough patients should be directed to inhale constantly from a cloth saturated with a solution of menthol, and placed beneath the chin. Besides this the nose and throat are sprayed daily, taking care to project the spray into the throat just at the beginning of inhalation. The paroxysms of cough were lessened in intensity and frequency, and the course of the disease appeared to be shortened. Bronchitis does better with this treatment than with other topical applications or with internal medication alone. The spray should be inhaled after a forced expiration, and retained as long as possible in the bronchial tubes before the next inhalation. This brings the fine smoke-like vapor in contact with the diseased surface. It is best to have patients inhale it through the nose, and it can readily be seen pouring out of the nostrils for several seconds, after a forced retention, showing that the respiratory tract is thoroughly medicated. The effect is distinctly felt deep in the chest.

In catarrhal conditions of the Eustachian tube and middle ear the author has employed menthol on account of its effect in relieving turgescence and stenosis in the nasal passages. He uses it in an inhaler as iodine crystals are ordinarily used, substituting cotton for sponges. If a stronger impression is desired, the liquid albolen solution is employed. Simply throwing the spray against the Eustachian orifices with the atomizer, produces a thorough impression on the tube and tympanum.

Suppurative inflammation of the middle ear readily yields to the menthol treatment.

Long standing cases are rapidly healed after the use of a twenty-per cent. solution. Furunculosis of the ear has been more amenable to this than to any other remedy. A pledget of cotton, moistened with a twenty-per cent. solution, should be so placed that it will remain in contact with the center of the furuncle. A warm or burning sensation follows, but soon gives place to one of coolness. The pain is relieved, the bacteria destroyed, and the swelling and discharge checked.—*Medical News*, July 26th, 1890.

Chloralamid.—Dr. Chas. H. Steele has successfully employed this drug in conquering insomnia, and particularly that form denominated simple or ideopathic insomnia, not due to excitement or severe pain. It is, furthermore, possible for the wakeful patient to enjoy several nights of natural sleep after a single dose. The best results occur when the drug is used in insomnia due to nervousness, neurasthenia, hysteria, "spinal disease" or old age; next best when the causes are chronic alcoholism, alcohol excess, cardiac and bronchial asthma, pleuritis, phthisis, pericarditis, arterial sclerosis, organic heart disease, typhoid fever, gastritis, subacute nephritis, ascites, diabetes mellitus and in the morphine habit. It is less effective when wakefulness is due to tabes dorsalis, neuralgia, progressive paralysis, the excitement of insanity, cerebral softening with delirium, melancholia, chronic mania and acute mania. In these conditions, doses of from thirty to sixty grains are required, providing such doses are tolerated.

The drug is useless when the insomnia results from paralytic dementia, maniacal excitement or hallucinations, severe neuralgia or other pain, violent cough, distressing headache, delirium of cerebral apoplexy, and from delirium tremens.

Even pain, when not acute, is often relieved, and the large doses necessitated are, by many patients, preferred to morphine.

Chloralamid, in doses of from twenty to sixty grains, has checked the pains of thoracic aneurism, carcinoma of the stomach and liver, sarcoma of a rib, erysipelas, rheumatic fever, floating kidney, neuralgia, gallstone, varicose ulcer, and alcoholic neuritis.

In chorea, a boy of eleven years of age was cured in five days by fifteen grains of the drug three times daily, and in like manner, a girl, after receiving no benefit from other forms of treatment, was afforded relief in eight days.

When administered in phthisis it was found that the troublesome night sweats disappeared.—*Pacific Medical Journal*.

Treatment of Cystic Goitre, Ranulae and Other Cysts with Chromic Acid.—Dr. Edward Woakes reports three cases of cystic goitre in which he adopted the following treatment. After evacuating the contents of the cysts by a trocar, he introduced a canula, and through this applied chromic acid on a carrier to the walls of the cavity. The result was very satisfactory, a rapid obliteration of the cyst taking place. In another case of large ranula which had resisted other treatment, the application of the acid caused rapid healing in less than a fortnight.—*Lancet*, June 21, 1890.

Euphorbia Pilulifera.—This drug has been given by Workman (*Ther. Gazette*) in twenty-seven cases, with these results:

In thirteen cases of hay asthma, prompt relief ensued in nine; partial in one, and none in three.

In nine cases of coryza, good results were obtained in six.

In five cases of asthma, marked relief was experienced in one only.

The fluid extract was given in doses of 30 to 60 minims every four hours.—*Times and Register*.



TWO Reliable Formulæ For Physicians' Prescriptions:



PIL. SUMBUL COMP.

(WM. R. WARNER & CO.)
(Dr. Goodell.)

R—Ext. Sumbul.....1 gr.
Assafœtida.....3 gr.
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Ac. Arsenious.....1-30 gr.

"I use this pill for nervous and hysterical women who need building up." This pill is used with advantage in neurasthenic conditions in conjunction with Warner & Co.'s Bromo-Soda, one or two pills taken three times a day.

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Sulphur.....½ gr.

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This combination is very useful in relieving various forms of Dyspepsia and Indigestion, and will afford permanent benefit in cases of enfeebled digestion, where the gastric juices are not properly secreted. As a dinner pill, Pil. Digestiva is unequalled, and may be taken in doses of a single pill either before or after eating.

ANTISEPTIC PASTILLES.

Echondroses of the Septumnarium—Their Removal and Treatment.

By CARL SEILER, M. D.

(From *Medical Record*, February 18, 1888.)

"Before I proceed with the operation, however, in a given case, I treat the nasal mucous membrane with a view to reduce the existing hyperæmia, for it is my experience that, if any surgical interference is undertaken at once, the shock following the operation is much more severe, and the wound does not heal as kindly nor as rapidly as when all acute or subacute inflammation has first been removed. For this purpose I use a spray of an alkaline solution, and make local applications with glycerole of iodine by means of a cotton carrier. Formerly I used the ordinary Dobell's solution for the spray, and also as a wash to be sniffed up the nose by the patient, morning and night, but within the last two years I employed instead a solution composed of the following ingredients:

Sodii Bicarb. et Sodii Bibor.....	ss 3 viij.
Sodii Benzoate et Sodii Salicylate.....	ss gr. xx.
Eucalyptol et Thymol.....	ss gr. x.
Menthol.....	gr. v.
Ol. Gaultheria.....	gtt. vj.
Glycerine.....	℥ viiiss.
Alcoholis.....	℥ ij.
Aque.....	

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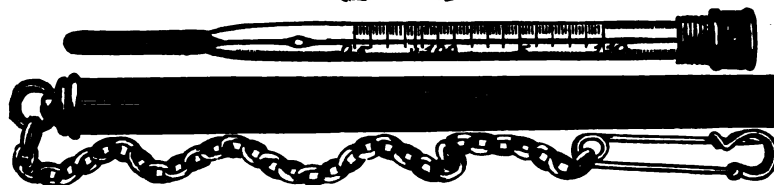
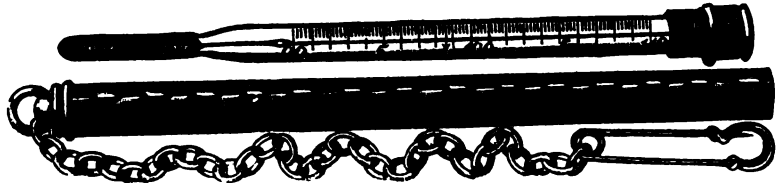
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